Office of Medi-Cal Procurement
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Access to Independence Response to:

Part 2: Questions for Interested Parties (including potential contracted entities): (please limit to 10 pages)

1. What is the best enrollment model for this program?

2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?

- Transition counseling—discharge planning based on assessment and consumer preference, evidence-based transition care program (e.g., Coleman Model) to insure the successful transfer of individuals from a facility to the home setting
- Housing assistance—full range: help finding housing; funding of first and last month's rent and deposit; procuring furniture, supplies, food, medication, adaptive equipment or home modifications; assistance with managing housing and supports
- Prevention of known potential secondary conditions of disability
- Any necessary community integration services
- All 1915(c) Medi-Cal Waiver Services
- Provision of coaching or mentoring as appropriate

3. How should behavioral health services be included in the integrated model?

Standards should be required for specific expertise (plan-provided or sub-contracted) in working with disabled persons and older adults.

4. If you are a provider of long-term supports and services, how would you propose participating in an integration pilot? What aspects of your current contract and reimbursement arrangement would you want to keep intact, and what could be altered in order to serve as a subcontractor for the contracted entities?

Access to Independence has what health plans need for full community integration: a long history of success in motivating consumers toward self-sufficiency, self-care management, and self-advocacy. Also, this agency has hundreds of deinstitutionalization successes from nursing homes and rehab centers that easily lend to the hospital to home transition need after elderly and disabled persons have acute events. Community integration services are available for health plans to purchase under sub-contract.

5. Which services do you consider to be essential to a model of integrated care for duals?

In addition to the items listed in #2 above, emphasis needs to be placed on: potential co-morbid condition prevention activities, equipment needs/improved access in primary care settings and for consumers, health coaches or mentors to help improve outcomes, increased payment for primary care physicians to provide an incentive to treat the "whole person" rather than the current problem; and integrated care coordination and management.

6. What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?

Providers: disability training, geriatric education, sensitivity training toward both these groups, care management training, health coaching or mentoring, community resources, filling the funding gaps for poor persons.

Beneficiaries: range of choices, knowledge of the health plan's quality assurance program, self-care management, self-advocacy, transition care, and healthy lifestyle choices.

Stakeholders: how to support the consumer or beneficiary, and quality expectations for health plans.

7. What questions would you want a potential contractor to address in response to a Request for Proposals?

- How will quality be measured and guaranteed?
- What will be the case manager/health coach ratio?
- Do your providers meet the minimum access standard under ADA?

- How will your providers prevent potential co-morbid conditions in the elderly and disabled populations?
- What will be the incentive for your primary care doctors to assess and plan for the "whole person" at each visit?
- How will you integrate care coordination and home and community-based services?
- How will you insure successful transfer (no re-admission) from facility to the home setting?
- What is your plan for providing mobility services when needed, especially wheelchair evaluation, purchase, and repair?

8. Which requirements should DHCS hold contractors to for this population? Which standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc., prior to enrolling beneficiaries?

The highest standards of Medi-Cal and Medicare as these populations often cannot / do not have the capacity or energy to police the providers themselves.

9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area? n/a

10. What concerns would need to be addressed prior to implementation?

The integration of Medicare and Medicaid funding to provide the incentive for providing stabilizing home care services to prevent acute exacerbation of chronic conditions.

11. How should the success of these pilots be evaluated, and over what timeframe?

Beneficiary satisfaction and health outcomes over the life of the pilot.

12. What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of the project? What principles should guide DHCS on requiring specific approaches to rate-setting and risk?

California has studied rate setting with the SPD and dual population for years so knows what is being paid now. There are other models (e.g. Arizona's LTC program) that do risk-sharing and retrospective rate adjustment that seem to be

working well. Also, there are “dual” models, such as Massachusetts’ Senior Care Options Program to review.

Thank you very much for the opportunity to provide input!

Sincerely,

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